Cameron Air Service -Medical Exemption
COVID-19 Immunization

Review the Medical Exemptions to COVID-19 Vaccination guidance prior to certifying a medical exemption to ensure all criteria are met.

Section 1 – Individual Information

Last Name	First Name	DOB (yyyy/mm/dd)

Home Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Section 2 – Declaration of Physician or Registered Nurse in the Extended Class (Nurse Practitioner)

I, _____
(Name of physician or registered nurse in the extended class)

certify that, for medical reasons, the above named individual is unable to receive a COVID- 19 immunization with the current COVID-19 vaccines available in Ontario (*Pfizer-BioNTech COVID-19 vaccine, Moderna COVID-19 vaccine, AstraZeneca/COVISHIELD COVID-19 vaccine*)**.**

Selection	Condition and/or Adverse Event Following Immunization
1. **Pre-existing Condition(s)**	
	Severe allergic reaction or anaphylaxis to a component of a COVID-19 vaccine
	Myocarditis prior to initiating a mRNA COVID-19 vaccine series (individuals aged 12-17 years old)
2. **Contraindications to Initiating a AstraZeneca/ COVISHIELD COVID-19 Vaccine Series**	
	History of capillary leak syndrome (CLS)
	History of cerebral venous sinus thrombosis (CVST) with thrombocytopenia
	History of heparin-induced thrombocytopenia (HIT)
	History of major venous and/or arterial thrombosis with thrombocytopenia following any vaccine

3. Adverse Events Following COVID-19 Immunization

	Severe allergic reaction or anaphylaxis following a COVID-19 vaccine
	Thrombosis with thrombocytopenia syndrome (TTS)/Vaccine-Induced Immune Thrombotic Thrombocytopenia (VITT) following the Astra Zeneca/COVISHIELD COVID-19 vaccine
	Myocarditis or Pericarditis following a mRNA COVID-19 vaccine
	Serious adverse event following immunization (e.g. results in hospitalization, persistent or significant disability/incapacity)

4. Other

	Actively receiving monoclonal antibody therapy OR convalescent plasma therapy for the treatment or prevention of COVID-19

Section 3 - Length of Exemption

Permanent		
Time limited	**From** **yyyy/mm/dd**	**To** **yyyy/mm/dd**

Section 4 - Signature

Business Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code
Signature of Physician or Registered Nurse in the Extended Class	**Designation**	**Date (yyyy/mm/dd)**